IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

July 7, 2006

Michael Day, PhD, Administrator
Independent Living Services-Summerwind
10332 Fairview Ave, Ste 103
PO Box 6395
Boise, ID 83711

RE: Independent Living Services-Summerwind, provider #13G013

Dear Dr. Day:

This is to advise you of the findings of the Medicaid/Licensure survey, which was concluded on June 29, 2006.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, CMS-2567, which states that no deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive

bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by July 20, 2006 and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

LOIS HOLLINGSWORTH, R.N.
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

SC/bjt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G013	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDEPENDENT LIVING SERVICES (SUMMERWIND)	**10349 SUMMERWIND DRIVE BOISE, ID 83704**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Independent Living Services Summerwind is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation. The survey was conducted by: Lois Hollingsworth, RN/HFS	W 000		

RECEIVED
JUL 27 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Board Chair | (X6) DATE: 7/12/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the building was in good repair and kept clean and sanitary for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. The findings include: During environmental observation on 6/28/06, from 3:00 p.m. - 3:25 p.m., the following issues were noted. 1. Woodwork throughout the facility was worn and in need of refinishing. 2. There was a build-up of mold in the shower stall in the master bath. 3. The top of the kitchen stove was in need of cleaning due to a build-up of burnt food/grease. 4. The trim on the West and South sides of the home was flaking/worn and in need of repainting. 5. The orange carpeting covering the 2 steps leading into the garage was heavily stained. It was in need of replacement. In addition, the metal plate at the bottom of the door had a black build-up. Cleaning was warranted.	MM380	RECEIVED JUL 27 2006 FACILITY STANDARDS (1) WE WILL REFINISH BY 12/06 BY Mike Day Maintenance Manager (2) DE-MOLDING CREW WILL ATTACK MOLD 7/31/06 BY Tami Mecham Facility Manager Maintenance Manager (3) CLEANING CREW WILL CLEAN BY 7/31/06 Monday Maintenance Tami Mecham (4) WILL BE REPAINTED BY 4/07 By Mike Day Maintenance Manager with Monitor Maintenance (5) WILL REMOVE CARPETING BY 9/06 Mike Day Maintenance Manager	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Facility Manager

(X6) DATE: 7/12/06